# THE IHS PRIMARY CARE PROVIDER

*A journal for health professionals working with American Indians and Alaska Natives*

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# Elder Care

This special issue of *The Provider* is dedicated to our elders and is being published in conjunction with National Older Americans Month. Our elders deserve not only our respect and recognition for all that they have accomplished, but they also merit our best efforts in ensuring their health and well-being. In this spirit, the editors have assembled this collection of articles devoted to the healthcare needs of the elderly.

Many of you are familiar with the Elder Care Initiative of the Indian Health Service (IHS), described by Dr. Stenger on page 54. Although the IHS requested $5 million to support initiatives in Elder Care, no specific funding was allocated by Congress for this fiscal year. While this might suggest that little could be accomplished, there has been, in fact, a lot of progress.

Many IHS Areas have established Elders Committees to examine policy and program issues. There are also partnership committees established between the IHS and tribal facilities that focus on service and advocacy matters. One example of an outcome of these committees is the *Resource Guide to Services for Native American Elders*, published by the Phoenix Area Elders Committee. This guide serves as a practical directory of services and programs for seniors in Arizona.

There are also important linkages being formed between the IHS and outside groups, ranging from geriatric education centers to other government agencies. Publications such as *Working with Your Older Patient: A Clinician's Handbook* (from the National Institute on Aging) or the Agency for Health Care Policy and Research *Clinical Practice Guidelines* (much of which applies specifically to the elderly) have been made available throughout the IHS. These are examples of what can be done with existing resources when we work together.

> *"Our elders deserve not only our respect and recognition for all that they have accomplished, but they also merit our best efforts in ensuring their health and well-being."*

Our elders have always been our pathfinders. They have shown us the way to live, to act, and to be. We owe them a great deal. We owe it to them to do everything we can to ensure that all their health care needs are met.

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## In This Issue...

# The IHS Elder Health Care Initiative

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The Indian Health Service (IHS) has historically provided health care to Indian elders as they present to IHS facilities for acute complaints, chronic disease follow-up, or hospitalization. While American Indian elders 60 years and older account for only 8.3% of the American Indian population,[1] their numbers increased 52% during the decade 1980-1990[2] and are expected to triple by the year 2030.[3] The IHS is exploring avenues for improved health care delivery to approximately 100,000 elder American Indians and Alaska Natives in response to the substantial growth of this population during the last decade, elder's demands for more services, and a shift over the last 50 years in prevalence from acute and infectious diseases to chronic and degenerative ones.

In October 1995, the Director of the IHS, Michael H. Trujillo, MD, MPH, implemented an Elder Health Care Initiative (EHCI) charged with developing an Elder Health Care Program (EHCP) for American Indian and Alaska Native elders. The Initiative team is composed of three Indian Health Service professionals (the authors) at Headquarters in Rockville, Maryland, and work groups consisting of Indian elders, individuals active and knowledgeable in elder care issues, members of national Indian organizations, and an IHS-wide interdisciplinary focus group.

The laudable efforts of the IHS Workgroup on Aging in 1991-1992 preceded the current Elder Health Care Initiative and have provided a background and understanding of issues and basic goals for the present project. The groundwork forged by the Workgroup on Aging included reviewing long-term care issues, identifying the array of elder services needing coordination and networking, recommending short- and long-term goals for elder health, and proposing an action plan and concept document for an IHS Elder Health Program manual. An excellent summary of the Workgroup on Aging activities was reported by Heath, Ornelas, and Marquart in the May 1993 issue of *The Provider*.[4]

The action plan and program goals of the Workgroup on Aging have been incorporated into a series of goals statements that are being examined by a number of American Indian elders as well as Board members of the National Indian Council on Aging, the Navajo Area Agency on Aging, the Intertribal Council of Arizona Area Agency on Aging, and the New Mexico Indian Council on Aging. In March 1996, an IHS-wide focus group composed of the IHS Elder Health Care Initiative representatives, 12 Area Elder Contact appointees, and specific discipline delegates met. The purpose of this meeting was to share and disseminate knowledge of elder initiatives and programs in existence and to formulate an action plan for addressing elder care issues IHS-wide.

Broad goals of the EHCI include targeting prevention and immunizations, treatment of chronic and degenerative diseases, and assessing the elders' quality of life and their ability to live independently. More specific goals include the following:

1. Target provider and consumer education.
2. Improve elder access to care and continuity of care.
3. Provide maximal tribal involvement in the Elder Health Care Program.

Short-term and extended priorities of the Elder Health Care Program will include both geriatric and gerontologic education of providers of health care for older American Indians. Discipline specific, as well as inter- and multidisciplinary didactic and clinical education and training approaches are envisioned within the scope of the program. Due to budgetary and expertise limitations, members of the EHCI are in the process of surveying Native American Resource Centers; Geriatric Education Centers; Area Health Education Centers; and Geriatric Research, Education, and Clinical Centers (some of these are described elsewhere in this issue) throughout the country to determine what kind of educational programs are available, and to begin to assess the applicability of these to our needs.

In addition, networking has begun with governmental and non-governmental agencies such as the Administration on Aging, Area Agencies on Aging, the National Institute on Aging, the National Indian Council on Aging, and the American Association of Retired Persons to build a repository of resources and stimulate partnerships while collating information regarding elder programs or initiatives within other Federal agencies, tribes, states, consortia, or other public or private organizations.

Anyone interested in more information can contact the

authors through the IHS e-mail or call us at 301-443-1840 or fax 301-594-6213.

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# Wellness and the Elderly


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## Introduction

More than any other ethnic group, the life expectancy of American Indians and Alaska Natives (AI/AN) has dramatically increased during the last half century. While life expectancy for whites increased 12.1 years (from 64.2 in 1940 to 76.3 in 1991), life expectancy at birth for American Indians and Alaska Natives (AI/ANs) increased 22.5 years (from 51.0 years in 1939-1941 to 73.5 years in 1990-1992).[1,2]

Since 1973, mortality rates for specific health problems in AI/ANs have decreased dramatically, for example tuberculosis (79%), gastrointestinal diseases (76%), maternal deaths (68%), infant deaths (58%), and accidents (56%).[1]

Factors that may have contributed to decreased mortality rates and increased life expectancy in AI/ANs include advances in medicine; increased access to health care; increased health awareness and request for health services; collaborative assistance of private, state, and academic resources with the Indian Health Service and tribal programs; research into diseases causing excessive morbidity and mortality in AI/ANs; and effective community and preventive health programs (including immunization initiatives, injury prevention, alcohol and substance abuse programs, and sanitary facilities construction and maintenance).

Traditionally, the Indian Health Service has provided health care for Indian elders as they access IHS facilities with specific complaints or when hospitalized for acute illness; few programs have specifically addressed the needs of elders as a group. As mortality from infectious diseases, childbirth, and accidents have decreased, and life expectancy has increased, wellness has emerged as an important aspect of health care. Although illness care and wellness care are both important for all ages, the concept of wellness is becoming more important in the elderly.

But what is wellness? According to the World Health Organization, "health is more than the mere absence of disease, but is a state of complete physical, mental, emotional, [spiritual,] and social well being.[3] This implies provisions for achievement of desired financial, family, and career goals. Expanding on this definition of health, "wellness" might be defined as a state of optimal health.

To address the issues related to wellness, health care providers must work with the elderly as our clients or partners, rather than as patients. Together, we need to identify strategies to maintain or improve wellness by preventive and maintenance care that improves the quality of life. This effort must be a multi- disciplinary effort, and should include traditional (illness) and not so traditional (wellness) services. It may also require the development of specific programs to help ensure that the needs of the elderly are met.

This paper will present a review of the health status of elder Americans; examine some special considerations in the AI/AN elderly; offer a "prescription for wellness" to be applied in the care of the elderly client; and make some recommendations for development of an orderly plan for quality, proactive health care for the elderly.

## Demographics of the American Indian Elderly

Today, more than 50% of AI/ANs live in urban areas.[4] This is also true of the Indian elderly. If living in a city, the Indian elder may not have IHS facilities available, and he/she is less likely to have immediate family or tribal support than their rural counterpart. Twenty-seven percent of AI/AN elders 65 to 74 years of age live in poverty (compared to 10.4% U.S. all races), while 33.3% of AI/ANs 75 years and older live in

poverty (compared to 16.5% U.S. all races).[1]

While poverty is often a problem, the National Indian Council on Aging states:

> Indian elders frequently become the sole provider in some families due to the fact that unemployment on . . . reservations is so high . . . that it forces younger family members to depend on the elder's Social Security, SSI, or Welfare income. This is leading to an alarming increase in exploitation and abuse of Indian elders.[5]

The National Aging Resource Center on Elder Abuse adds that alcohol abuse among younger family members has also contributed to financial exploitation and abuse of American Indian elders.[6]

There is a high level of non-participation by AI/AN elders in Federal income support programs (either Social Security or Supplemental Security Income). Twenty percent of rural and reservation AI/AN elders age 65 to 74, and 15% over age 75, are non-participants in these income support programs, with women being even less likely to participate than men.[7]

AI/AN elderly comprise the most rural of all minority populations. Specific population statistics are presented in Tables 1 and 2. In 1980, 50% of AI/AN elders lived in rural areas, double the proportion of white elders. Findings from the 1980 Census reflect the difficulties experienced by many AI/AN elders: 50% had no telephones, 16% lacked electricity, 17% had no refrigerators, and 21% had no indoor toilets.

Table 1. Distribution of IHS service population, aged 60 and over, by IHS Area, 1993.

| IHS Area | Number Age 60+ | Number All Ages | Percent of Total Population |
|---|---|---|---|
| Aberdeen | 6,057 | 85,800 | 7.06 |
| Alaska | 6,596 | 94,170 | 7.00 |
| Albuquerque | 5,386 | 72,067 | 7.47 |
| Bemidji | 5,154 | 65,799 | 7.83 |
| Billings | 3,412 | 51,019 | 6.69 |
| California | 9,690 | 113,684 | 8.52 |
| Nashville | 5,193 | 56,045 | 9.27 |
| Navajo | 14,938 | 199,836 | 7.47 |
| Oklahoma | 30,969 | 276,411 | 11.20 |
| Phoenix | 7,998 | 124,445 | 6.43 |
| Portland | 9,689 | 136,422 | 7.10 |
| Tucson | 2,052 | 27,025 | 7.59 |
| Average for all IHS Areas | | | 8.23 |

Source: Division of Program Statistics, OPEL, IHS[8]

Table 2. Distribution of service population, selected geriatric age groups, 1993.

| Age Group | Number | Percent of Service Population |
|---|---|---|
| 60-64 | 32,386 | 2.49 |
| 65-69 | 27,110 | 2.08 |
| 70-74 | 19,124 | 1.47 |
| 75-79 | 14,252 | 1.09 |
| 80-84 | 8,090 | 0.62 |
| 85+ | 6,253 | 0.48 |
| Total AI/AN ages 60+ | 107,215 | 8.23 |
| Total AI/AN all ages | 1,302,723 | 100.0 |

Source: Division of Program Statistics, OPEL, IHS[8]

There are few retirement villages/housing developments, protected living arrangements, or sheltered environments for the AI/AN elderly, as are common in other populations (e.g., Sun City and Green Valley, Arizona), and such special arrangements are a low priority for Housing and Urban Development Agency funding. There are few AI/AN operated nursing homes (see insert, p. 61).

Hospital discharge rates are substantially (37%) lower for AI/AN elders than those of the comparable U.S. population, and their use of outpatient services is also lower than the general U.S. population. It is unknown whether this reflects lower morbidity, decreased access to services,[8] or reluctance to use Western medicine. While AI/AN elders use fewer services than elders in the general population, they do use more services than any other AI/AN age group. Demographic data show that AI/AN elders age 65 and over constitute less than 6% of the IHS user population, however, they consume 19% of all hospital stays, 10% of outpatient visits, 20% of public health nurse visits, and 38% of community health representative visits. The average length of hospitalization is 147% longer than for all ages. Yet elders also generate a high proportion of third party (Federal and state) reimbursement from both Medicare and Medicaid, which softens the financial impact. For services delivered in fiscal year 1991, IHS Medicare collections totalled more than $35 million.[8]

The seven leading causes of death for AI/AN elders are heart diseases, malignant neoplasms, cerebrovascular disorders, pneumonia and influenza, diabetes mellitus, chronic obstructive pulmonary diseases and allied conditions, and accidents.[1] Available IHS mortality data indicate a trend of increasing mortality due to cancer, diabetes, obstructive pulmonary disease, septicemia, and nutritional disorders for AI/AN elders. Smoking and obesity have a high prevalence. Cancer survival rates are the lowest and alcohol-related mor-

tality is substantially higher for AI/AN male elders than for any U.S. subpopulation. The findings from the National Medical Expenditure Survey (conducted in 1987) indicate that older Indian women are far less likely to have had breast exams, mammograms, or Pap smears than the general U.S. population.[8]

### Health Problems in the Elderly

**Heart disease.** Heart disease is presently the leading cause of death of the elderly (AI/ANs, U.S. all races, and U.S. whites), with women having mortality rates that are equal to those of men within 10-15 years after onset of menopause. The natural ovarian hormone, estrogen, is cardioprotective until menopause, at which time natural estrogen declines dramatically and the serum lipid profile changes. In addition to the usual preventive measures (e.g., diet, exercise, cessation of smoking), hormonal replacement therapy (HRT) has a profound beneficial effect on blood lipids, and reduces the risk of ischemic cardiovascular disease in those women receiving it. It has been suggested by some that HRT may not be needed in those ethnic groups that have clinically low incidences of osteoporosis (e.g., AI/ANs, Blacks), however, HRT is indicated for its cardioprotective effects.

An important risk factor for heart disease is either primary or secondary exposure to tobacco smoke, which constricts coronary arteries and alter blood lipids. Tobacco also serves as a primer for other carcinogens in multiple systems, and decreases the safety of HRT.

**Osteoporosis.** It is often assumed that the incidence of osteoporosis is low in AI/ANs, however, specific data about osteoporosis in Indian elders is currently unavailable. The following information pertains to the general population.

Osteoporosis (defined as decreased bone mineral density, BMD) is more common in females, probably because females start out with smaller and lighter bones, there is some calcium loss with pregnancy, and estrogen does not put on bone substance (or retard bone substance loss) as well as testosterone does. Data show that, especially in males, decreased BMD correlates with in-creased loss of teeth in the elderly. Studies are just beginning to show that de-creased BMD means increased loss of teeth in women also. Loss of dentition is frequently a precursor to poor nutrition.

A major predictor for increased dependency and de-creased life ex-pectancy is de-creased mobility (specifically, lack of ambulation). Decreased BMD correlates with increased hip fractures, with subsequent loss of mobility and independence, and de-creased quality of life. In the U.S., the lifetime risk of fractures of the spine (symptomatic), hip, and distal radius is 40% for women and 13% for men from 50 years of age onwards.[9] As a result of hip fractures, 10% to 20% of patients die within six months, 50% are unable to walk without assistance, and 25% will require long-term nursing home care.[9]

Although advanced osteoporosis can be diagnosed using standard x-ray equipment and technique, early BMD changes can only be diagnosed using special bone densitometry equipment. The IHS does not have bone densitometry capabilities at any of its facilities, and screening for BMD might be perceived by some as having low priority for use of contract health service funds because of the general belief that osteoporosis is not a problem in AI/ANs.

Hormone replacement therapy (HRT) has been shown to dramatically reduce the incidence of osteoporosis (and fractures due to osteoporosis) in women who begin treatment in the perimenopausal years. Calcium supplementation and weight-bearing exercise contribute to bone density.

It is important to note that patients on long-term steroid

## Research on Aging and Health

Over the years, most research studies have focused on men, assuming that findings would be relevant to women as well. Reflecting a recent change in direction, a 12-year study of women 49-79 years of age, The Women's Health Initiative, has been funded by the National Institutes of Health. This first-ever, large scale, nationwide study of a female population is designed to obtain health data on the postmenopausal woman, and to use those data for determining/establishing norms of care for this group. The women involved will have the results of annual exams recorded, analyzed, and catalogued over the 12 years of the study. Most medication interventions in the Women's Health Initiative are to be double blinded, but there will also be women who will only be observed or have only dietary interventions. Annual studies of bone mineral density will be included. Final results are not expected until the early part of the next century. In addition to focusing on older women, special efforts are being made to include representation from various ethnic groups. At one study center, the University of Arizona Health Sciences Center, 60% of the subjects will be from minority populations; one-third of these will be American Indians.

Other large studies (the Framingham study, the Nurses Health study, and the Doctors Health study), gathering tremendous amounts of data over the years, are just beginning to analyze and apply their findings to the health care of the elderly; none of these studies were done in minority populations.

therapy are at high risk for osteoporosis; HRT is indicated for these women. Smoking and alcohol abuse also put women at increased risk for osteoporosis.

In those who already have osteoporosis, two non-hormonal drugs are currently available that have demonstrated the ability to increase bone density and decrease fractures: calcitonin (Calcimar, Mia-calcin) and alendronate sodium (Fosamax). In addition to medications, steps should be taken to reduce the risk of fractures by protecting elders from falls. Ap-propriate exercise can increase muscle strength, improve joint mobility, and im-prove the sense of balance, all important strategies to prevent falls in the elderly. Securing throw rugs and avoiding slippery and hard floors are but two of many preventive measures to protect against falls. A brochure that details adapting or modifying a home for an elder while enhancing their independent living is available from the American Association of Retired Per-sons (AARP).*

**Cancer.** Patterns of cancer incidence vary with sex, race (with substantial differences among tribes), and geographic location. Among American Indian communities in the Southwest, cancer rates have been found to be generally lower than those for U.S. whites, while cancer rates in Alaska Natives and Eastern Cherokee women approach those of U.S. whites.[10] Lung cancer is the most frequent cancer among AI/AN males (followed by prostate cancer) and the fourth most frequent among women, trailing breast, colorectal, and cervical cancer. Cancers of the gallbladder, stomach, and cervix show generally high rates among many AI/AN communities, and cancers of the liver and nasopharynx are high in Alaska Natives.[10]

Although there are many specific risk factors (depending upon the organ or tissue involved), many cancers are diseases of aging, with incidence increasing with longevity and early or prolonged exposure to specific risk agents. Risk factors for cancer include, but are not limited to, hereditary traits, occupational exposure (e.g., radiation, asbestos, benzene), alcohol abuse, tobacco use, medications, and exposure to certain viruses.

The sequelae of advanced cancer are prolonged pain and debilitation, and finally death. To enhance wellness and quality of life, it is important that we identify and modify known cancer risk factors, and that we initiate programs for early detection of cancer while still curable (primary and secondary prevention). In addition to educating clients about lifestyle modifications (such as increasing fiber and reducing fat in the diet, and cessation of tobacco use), Indian health programs should actively support screening activities for detection of cervical, breast, colon, and prostate cancer.

While AI/AN women are seen for routine Pap smear screening often during their reproductive life, Pap smears become infrequent after menopause, even when women are being followed for other medical problems.[11] Programs to encourage the routine Pap smear in the older female, even when that screening is not done with the desired or recommended frequency, are still far better than no Pap smear at all. The importance of coming in for Pap smear screening is magnified by the fact that this screening examination almost always includes screening for breast and colon cancer, in addition to cervical cancer. Many states have received grants from the Centers for Disease Control and Prevention for programs designed to increase screening for and detection of cervical and breast cancers in minority women. Programs should be initiated or modified to effectively employ these supplemental resources.

**Alzheimer's disease.** Alzheimer's disease, a dementia characterized by memory loss and a deficit of at least one other cognitive skill, robs many elders of their ability to function normally. While memory loss related to recent events occurs in Alzheimer's and can be problematic to both elders and their families, forgetfulness, by itself, is not diagnostic of Alzheimer's disease, and the elder and family members should be reminded of this fact. In Alzheimer's disease, personality and behavioral changes may occur (including restlessness, agitation, physical outbursts, wandering, and disinhibition), over time, that necessitate continuous monitoring. Alzheimer's affects more females than males, has a gradual rather than sudden onset, and, over time, frequently results in institutionalization. No medications are presently available that can treat the malady effectively.

**Suicide.** Depression is often the trigger for suicide. Depression in the elderly should be looked for, recognized, and treated. Triggers for depression may include loss of a companion, spouse, or friend; serious illness (especially a life threatening or disabling illness); displacement from home; illness of a companion, spouse, or friend; lack or loss of family or community support; and social isolation, which may be increased due to physical separation and isolation of homes and living arrangements in rural locales.

National data on suicide show rates in AI/AN elders to be approximately one-third the U.S. all races rate.[12] Recent Arizona state statistics and Phoenix Area IHS statistics show the rates increasing in this group (data from Mental Health Program).

## Quality of life Predictors for Elders

Personality, attitude, culture, life experiences, and other factors may impact the relative importance of any one of the following predictors of quality of life in the individual elder.

1. *Absence of poverty*. Higher income appears to facilitate adjustment to and satisfaction with retirement. Absence of poverty (rather than presence of wealth) seems to be the main socioeconomic predictor for quality of life in the elderly population. In 1990, 27% of AI/AN elders 65 to 74 years of age, and 33.3% of those 75 years and older,

* American Association of Retired Persons, 601 E Street, N.W., #5B, Washington, DC 20049 (phone: 202-434-2200).

lived below the poverty level.

2. *Good health.* Good health means that individuals do not have to modify their lifestyle because of illness. Poor health is strongly associated with lower morale and lower levels of satisfaction in the elderly. It follows, therefore, that primary and secondary prevention are important factors in enhancing quality of life.
3. *Adequate dentition.* Adequate dentition is an important factor in achieving good nutrition. Diabetes is a cause of dentition loss through diabetic periodontal disease. Osteoporosis, with its general decrease in BMD is frequently a precursor to loss of teeth. Loose fitting dentures also may make eating difficult, especially as bone is absorbed around the base of the denture.
4. *Mobility and ambulation.* A risk factor for dependency and institutionalization is decreased mobility. Of individuals in nursing homes or retired living facilities, loss of independent mobility is often a precursor of illness. Recent studies have shown that walking at least four hours a week (35 minutes a day) "postpones" heart disease.
5. *Interaction with others.* A social network may be the source of encouragement to participate in social and physical activities, which in turn may contribute to a feeling of well-being and satisfaction. In addition, interactions with family and friends can provide emotional and psychological support, open up opportunities for physical activity and companionship, allow use of intellectual and language skills, rekindle friendships/alliances, and allow the elderly to make positive contributions to others. Access to traditional healers may be important to many elder AI/ANs, and should be considered in the treatment plan. Programs need to be established to integrate elders into the community to demonstrate and utilize the worth and value of these individuals.
6. *Personal security.* Because of actual or potential physical fragility in elders, they become victims to elder abuse, "con games," burglary, and assault. Elders may become isolated because of fear (of crime) or confinement by caretakers (elder abuse). Programs need to be developed to recognize, prevent, and manage elder abuse and neglect. The elderly are entitled to a safe and secure living environment.
7. *Ability to be productive, contribute.* Productivity is not a function of age. For those who feel they are not making a "contribution" (whether that be to family, their people, humanity, or to their work), feelings of worthlessness, hopelessness, and depression can arise.

## A Prescription for Wellness

While it cannot be said that the health care system can (or should) entirely provide for the elder, for this is often a social or community responsibility, health care professionals are in a unique position to recognize needs and participate in organizing approaches to meet these needs. Health care providers may be the only contact that the elder has with persons who are in a position to identify and advocate for their needs. In the case of the well elder, the only contact with the health system might be the community health nurse or community health representative.

Proper care of the elder is a multidisciplinary activity and responsibility that cannot be done completely or comprehensively by any single discipline. Health care providers need to work together to develop and maintain a comprehensive approach to care of the elderly. Community resources also need to be generated and mobilized.

The following elements are needed in the implementation of "the prescription for wellness."

- *Safety.* Elders need to be secure and safe, protected from intentional and/or unintentional abuse and/or neglect. Reports should be made to appropriate agencies if elder abuse is suspected, and living arrangements may need to be altered to provide protection.
- *Economic security.* Many AI/AN elders are eligible for receipt of services of which they are unaware. Social Security and Medicare have provisions for basic needs and medical care, with Medicare entitlements often exceeding baseline IHS services. As poverty is still a major life factor in the AI/AN elderly, the provider should assure that all potential entitlements are applied for, and actively assist in the application process if such assistance is needed.
- *Mobility/independence/ambulation.* Maintaining mobility and ambulation is a quality of life requirement, as once ambulation is lost, it is infrequently regained. Ambulation is good for the skeletal and muscular systems, and is cardioprotective as well.
- *Opportunities for social interaction.* The elder should be able to communicate with others of similar age and background if desired, and to meet for social activities and interaction. Senior centers, congregate meals, and day care programs provide opportunities for social interaction and contact of the elder with others. These programs provide not only enhanced nutrition, but serve as a means for social interaction and intellectual stimulation. For many individuals, a "community meal" will be the major and most important meal of the day, especially if depression is present.
- *Opportunities for spiritual activity.* Spiritual activity provides the opportunity to examine life/self/existence, and allows one to contribute on one's own terms, consistent with beliefs and culture.
- *Periodic screening for disease.* Periodic screening allows for early diagnosis, and should be combined with health education aimed toward primary prevention. Recommendations for specific screening activities in elders are available.[13-15] Screening should be tailored

toward the individual's own needs and directed toward known risk factors in the individual's personal profile. A regular visit schedule should be set up for health maintenance visits, regardless of the state of, or presence of, any specific disease. This could be called: "Screening for Quality of Life."

- *Simple, not complex medical care.* Care should be delivered on the individual's own terms, and be no more complex than desired. This means that intake must occur to ascertain what those terms and desires are, and adaptations made to conform. Generally, the older the person, the more simple the plan must be.

  Compliance with treatment can be difficult and confusing for the elderly population, as there is a tendency to have multiple medications prescribed as age increases (due to degenerative diseases). In addition, as the number of medications increases, so does the potential for drug interactions. The habit of simply marking medications, "Take as directed," should be strictly avoided. *Specific and complete, detailed instructions* should be placed on each medication label so as to form a ready reference for the patient/client. Providers need to be sure that patients understand the instructions for the medications prescribed, that the dose is appropriate for the patient's age and general health status, and that there are no known drug interactions among all of the medications that the patient may be taking. Patients need to be advised that all medications should be filled or obtained at a single location, if possible, so that a medication log and/or discussion with a pharmacist about potential adverse reactions and drug interactions is possible. Inquiries need to be made about over-the-counter (OTC) medications the client is taking. If the elder is bilingual, instructions should preferably be given in the language in which the elder is most comfortable.
- *Avoidance of tobacco, and abuse of alcohol and other substances.* Any decrease in the amount of tobacco used will prolong life, and may increase the quality of the resulting prolonged life. Allowances should be made, however, for religious or ceremonial use. Alcohol is a direct toxin to the liver and brain, and ingestion of excessive alcohol leads to increased morbidity and premature mortality. Alcoholic cirrhosis remains a major cause of death in the AI/AN elderly.[1] The elder needs to be motivated to decrease such substance abuse, and to go into a treatment program if possible. The concept of giving up because of age and personal choice should only be a relative one. Because substance abuse is not always apparent, providers should screen for it routinely during their patient assessment. Screening for substance abuse offers health care providers the opportunity to identify and intervene when it is present.

## Recommendations

Assuming that care will be given by a multidisciplinary team, the following are clinical and program recommendations:

1. *Develop a proactive, anticipatory approach to the care of the elder, seeking health and wellness as the outcome.* Elders need to be seen on a regular schedule, apart from contacts with the health system for disease management. Plans should be individualized, taking into consideration the client's own aspirations and recommendations of various health organizations.
2. *Management plans should be integrated into the IHS Health Summary.* The current computerized Health Summary is now available throughout IHS, including many tribally-operated health facilities. Although it will take some time and concentrated effort, standard elder care recommendations and checklists should eventually be added to the standard IHS Health Summary, much as the standard immunizations and well child care recommendations now are.
3. *Health care plans should be integrated with social management plans.* Social history and activity is as important, often more important, than health data and assessment to the well-being of the elder. These data should be included in standard assessment.
4. *Increase geriatric knowledge throughout IHS.* As more geriatrics and gerontology trained individuals become available in IHS, tribal, and urban Indian programs, their knowledge needs to be disseminated to the field, so that the expertise will have direct impact on elder care. Special workshops and teaching materials are needed, with a plan for making information about care of elders universally available.
5. *Encourage assisted living projects to prolong independent living.* Consistent with individual desires and family wishes and resources, sheltered living facilities, as well as adult day care centers, should be encouraged. The development of such facilities can be expected to prolong independent living for the elderly, promote social interaction, provide a support network, and offer opportunities to continue making valuable contributions to their communities.
6. *Encourage more AI/AN owned and operated nursing homes.* Nursing homes within the community remain a viable and important option to facilitate continuing cultural and family ties for of the AI/AN elder who needs institutionalization. Communities need to explore and evaluate potential resources, including third party reimbursement, to make these facilities financially viable.
7. *Encourage more general and special data collection on the AI/AN elder.* Without information about the problems that exist, there can be no organized effort to strategize to find solutions. Regarding the AI/AN elderly, data collection should be IHS-wide and uniform and should include both general and disease-specific information. The diffi-

culty in finding AI/AN data that this author experienced should not persist. The data from the Women's Health Initiative should be widely disseminated as it becomes available. Special work groups should be developed in each IHS Area, with necessary data developed, collected, and disseminated widely. A repository for these data may also need to be developed, such as the National Indian Council on Aging.

8. *Set up an inventory of materials needed to establish quality geriatric care.* This inventory would include such items as equipment to measure bone density, mammography equipment, physiotherapy and occupational therapy adaptations for the elderly, and dental prosthetics needs. An alternative mode for service delivery should also be included or developed. Lessons from the special Geriatric Education Center programs need to be recorded, catalogued, and disseminated rather than rediscovered.
9. *Support more research into problems of American Indian and Alaska Native elders.* As stated in other portions of this paper, few data are available on American Indian and Alaska Native elders. The findings of previous research into disease conditions causing morbidity in the elder population is responsible, at least partially, for the growth in the elder population. Research into conditions affecting American Indian and Alaska Native elders and into successful strategies to deal with these conditions can lead to more effective health care planning, enhanced services, and potentially improved quality of life. Research should be encouraged and the findings shared.

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# Indian-Operated Nursing Homes

Nationwide, the major reason for nursing home placement (regardless of race/culture) is the inability to independently perform the activities of daily living, with sheltered living being inadequate for needs.

Indian-operated nursing homes are relatively "new entrants," with the oldest facility being the American Indian Nursing Home in Laveen, Arizona, opening in 1969. The data below are at least five years old. It can be seen that many of these facilities have a reversed male/female gender ratio compared to nursing homes in general, where the population tends to be predominantly female (3:1). The operation of these facilities reflects tribal response to a long unmet need: facilities located on or near the reservation. Indian-operated facilities allow patients to be placed closer to home permitting visits from family and friends. An added benefit is that staff at these facilities are often from the same culture.

The three most common diagnoses of the residents in these nursing homes are diabetes mellitus, alcohol abuse, and stroke.

| Facility | Number Beds | Designation | Proximity to Acute Care | Male: Female Ratio | % Indian Staff | Average Age |
|---|---|---|---|---|---|---|
| **American Indian** | **96** | **S,I,P,B** | **16 miles** | **2:1** | **83** | **66.2** |
| **Chinle** | **79** | **S** | **5 miles** | **Unknown** | **Unknown** | **Unknown** |
| **Blackfeet** | **49** | **S,I** | **immediate** | **1:2** | **94** | **72.0** |
| **Oneida** | **50** | **S,I,P,B** | **10 miles** | **1:1.3** | **71** | **83.0** |
| **Toyei** | **66** | **P** | **65 miles** | **1:1** | **91** | **82.0** |
| **Carl T. Curtis** | **25** | **I** | **10 miles** | **1:1** | **80** | **60-70** |
| **Whiteriver** | **20** | **P** | **5 miles** | **1:1.5** | **100** | **75** |
| **Laguna-Rainbow** | **25** | **I** | **4 miles** | **2:3.1** | **95** | **82.0** |
| **Colville** | **32** | **S,I** | **immediate** | **1:1** | **89** | **70.0** |
| **Morning Star** | **50** | **unknown** | **immediate** | **NA** | **NA** | **NA** |

S = Skilled care; I = Intermediate care; P = Personal care; B = Board and care.

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# The Elders' Clinic at Zuni

*Robin I. Miller, MS, RN, Clinical Specialist in Gerontology; and Bruce Finke, MD, Medical Director, Elders Clinic, PHS Indian Hospital, Zuni, New Mexico.*

The Elders' Clinic at the PHS Indian Hospital at Zuni, New Mexico, is a comprehensive, multidisciplinary geriatric assessment program available to elders with complex health problems. Eligibility criteria include recent onset of functional impairment, confusion, or falls; polypharmacy; or social crises. Clients may be referred by primary care physicians (the Zuni medical staff uses a family practice model), by the senior center, or by home health and public health workers.

The geriatric assessment team performs a comprehensive home safety assessment before the client is seen in the Elders' Clinic. Assessments by a gerontological clinical nurse specialist, a physician, a pharmacist, a psychologist, an audiologist, a dietician, a physical therapist, and a dentist take place during one two-hour clinic visit. The client's primary home caregiver is included in the assessment.

The team meets after the clinic to review findings and to formulate suggestions for changes in the current care plan to meet needs identified during the assessment. These suggestions are discussed with the patient and caregiver, and then relayed to the appropriate community support personnel and to the primary physician. Follow-up focuses on checking which suggestions were carried out and how helpful they have been to the client.

### Program Goals

The primary goal of the Elders' Clinic is to provide enhanced diagnosis and therapeutic planning for elders at risk in our community. While it is too soon to assess the long-term effect of this program (the first clinic was held in October 1995), the literature suggests that comprehensive assessment

programs of this type may decrease hospitalizations and nursing home placements, improve independent function, decrease polypharmacy, and improve patient perception of health and well-being. The quality assurance/improvement indicators being monitored are designed to assess some of these factors.

We hope that these geriatric assessments will become an educational tool for the medical and nursing staff of the hospital, promoting an enhanced appreciation for the needs of geriatric clients and an increased awareness of the importance of regular measurment and recording of functional assessment.

### The Program's Beginnings

Within the Zuni/Ramah Service Unit, we are fortunate to have individuals from many different disciplines who have strong backgrounds in geriatrics and gerontology. In early 1995, a working group of people who share this strong interest and expertise convened to discuss ways to enhance the care of the elderly at Zuni. We focused first on the comprehensive assessment clinic as a way to integrate the existing services, and to target the clients at greatest need for intervention. Over the past two years, the care of Native American elders has been selected as a priority area for development within the Indian Health Service (IHS). An interagency agreement between the IHS and the Administration on Aging was signed in late 1994 to encourage the development of shared resources, expertise, and training in elder care for Native Americans. The early efforts at Zuni harmonize well with this new emphasis on elder care within IHS.

### Program Support

At present, the Zuni Elders' Clinic receives no direct funding. Administrative support for the use of staff and clinic time has been crucial to its ability to operate. All involved team members have added the Elders' Clinic to their existing responsibilities. During the planning stages, a student was on site who helped with the literature search and with writing the proposals necessary to initiate the program. The costs of the assessment itself are borne by IHS, and by alternate resources when available. In the near future, we plan to seek grant funding through IHS to support the program as it develops.

### Accomplishments

While the program is still in its early stages and evolving, some early indications of success in meeting its goals are available. The majority (89%) of the team's recommendations have been implemented. Thirty-six percent of the clients have had reductions in the number of medications prescribed as a result of the assessment. Informal feedback from clients and caregivers has been positive.

The development of this team has resulted in closer and more effective working relationships with Administration on Aging and tribal programs in the community, such as the senior center and the Community Health Representatives.

### Future Directions

The geriatric assessment team plans to work to increase knowledge of aging issues in the local community through education. Training programs on aging will be provided within the hospital, and to interested professionals working in the community. Client and caregiver education will be aimed at increasing understanding of the changes that accompany aging, learning appropriate care techniques, and reducing caregiver burden through appropriate use of resources currently available.

The Elders' Clinic itself continues to be refined. Soon, optometry will be added to the assessment. Follow-up surveys or home visits will be done to assess client satisfaction with and follow through on team recommendations. In time, the Elders' Clinic will form the core of an integrated spectrum of geriatric services at Zuni.

### Acknowledgement

The Zuni Geriatric Assessment Team would like to acknowledge the invaluable work and vision of Linda Terrell, MSN, RN, Clinical Specialist in Gerontology, who in the past year worked tirelessly to make this idea a reality. ®

*SPECIAL ANNOUNCEMENT ®*

# Call for Papers

## Eighth Annual IHS Research Conference

The Eighth Annual IHS Research Conference will be held the week of August 12, 1996, in Albuquerque, New Mexico. More information will be in the next issue of The IHS Provider about: (1) the call for abstracts, and (2) the call for proposals from the National, Area, and Tribal Health Boards/Committees for their participation. The Conference will feature "lessons learned from research over the years."

# National Indian Council on Aging

*Dave Baldridge, Executive Director, National Indian Council on Aging, Albuquerque, New Mexico.*

Two decades after it was founded by a group of tribal chairmen, the National Indian Council on Aging (NICOA) aggressively continues to pursue its mission: to improve the lives of American Indian and Alaska Native elders. Although the nonprofit Albuquerque, New Mexico based organization is small (20 employees), it serves as the nation's foremost advocate for this disadvantaged segment of the American Indian and Alaska Native population.

Governed by a 13-member board of Indian elders, NICOA frequently testifies before Congressional subcommittees and advocates within the national aging network and with federal agencies. NICOA seeks alliances for advocacy with other aging organizations, and is a partner in several joint initiatives in Indian Country. NICOA frequently collaborates with tribal leaders, Title VI directors, other nonprofits, state Indian Councils on Aging, and intertribal organizations such as the National Congress of American Indians.

## NICOA and the IHS

Beginning with its participation in an ad hoc Technical Work Group of attorneys and advocates responding to the Administration's 1994 health care reform initiative, NICOA has played a positive role in health care advocacy, establishing several important relationships with the Indian Health Service (IHS). These include: (1) addressing elder health issues with the Council of Area and Associate Directors; (2) addressing several hearings before Assistant Secretary Phil Lee; (3) participating on an IHS Design Team work group; (4) completing, in cooperation with the Albuquerque Area IHS, an innovative computer project (May 1996) that will map the health and socioeconomic status of Indian elders; (5) initiating a successful effort to establish an Indian elder-focused Geriatric Education Center at the University of New Mexico Medical School; and (6) participating on the planning committee for the IHS's new Elder Health Care Initiative.

## NICOA Initiatives

**The University of New Mexico (UNM) Geriatric Education Center.** Because the IHS has initiated but not yet established a fully operational geriatric focus, NICOA last year initiated the development of a grant application to the Public Health Service. The result was a three-year, $695,000 award to improve the delivery of health care to American Indian elders. This grant is shared by a statewide consortium led by the UNM, teamed with NICOA, the IHS, the Sisters of Charity Health Care Systems, New Mexico State University (NMSU), and New Mexico Highlands University (NMHU). The grant establishes the consortium as a Geriatric Education Center (GEC), one of 11 funded this year by the U.S. Public Health Service.

The New Mexico consortium, operating out of the Center on Aging at the UNM, plans to build a system for educating and training the professionals who deliver health care to New Mexico Indian elders. In cooperation with NICOA and the Albuquerque Area IHS, the UNM's School of Medicine and Colleges of Nursing and Pharmacy will collaborate with the NMSU and NMHU Schools of Social Work to develop culturally sensitive curricula and approaches. The consortium will offer on site continuing education courses in geriatric health care for six IHS service units located in New Mexico. The courses will be taped and made available for use by other IHS Areas.

According to project director Robert Lindeman, Professor and Chief of the UNM School of Medicine's Division of Gerontology, "We hope to create a first-ever model training curriculum for Indian health providers, one that will result in a corps of trained service providers. In turn, they will directly improve the health and daily lives of American Indian elders, the nation's most disadvantaged elderly population."

**Mapping Indian elders.** This project, funded by the federal Administration on Aging, involves the Geographic Information System (GIS) computer mapping of targeted New Mexico Indian elder populations. Using multiple electronic databases, including 1990 Census TIGER files and the Indian Health Service Patient Database, a series of four-color maps are being generated and analyzed. Targeted populations are being mapped and compared according to their (1) geographic proximity to services, such as hospitals, clinics, and senior centers; (2) socioeconomic status, as determined by selected income and household data; and (3) health status according to IHS patient data (permissions were secured from Area and National IHS review boards).

The landmark project meets several goals: (1) to demonstrate that advanced computer mapping (GIS) technology can be applied to health and human services needs; (2) to demonstrate that data from multiple and varied sources can be incorporated into GIS applications; and (3) to illustrate the potential

of GIS applications to a variety of health and human service applications in the national aging network.

NICOA expects to present the project's final report in May to a federal interagency task force that includes Dr. Michael Trujillo, Direct-or of the Indian Health Service. NICOA believes that the use of GIS technology may have far-reaching implications for the entire Indian health delivery system.

**The NICOA Report: Health and Long-Term Care for Indian Elders.** Under a grant from the National Indian Policy Center (George Washington University), NICOA has completed this 107-page analysis of Indian elders' political, health, and functional status. Primary author Robert John of the University of North Texas has updated data from his IHS report, "American Indian and Alaska Native Elders: An Assessment of Their Current Status and Provision of Services," to incorporate 1990 Census information. The report includes a political analysis and recommendations by NICOA.

Scheduled for official release at a Senate Hearing in April, the report will be available (in limited quantities) upon request.* Points made in the conclusion of this report include: (1) essential geriatric and long-term care services still remain largely unavailable to Indian elders, (2) services for Indian elders have not been consolidated under one agency, making access to these services confusing and difficult, (3) the IHS should take a leadership role in the coordination and delivery of geriatric and long-term care services, (4) increasing numbers of tribes have contracts or compacts with the federal government to administer some or all health care services, (5) advocacy with tribal decision-makers for elder health issues may become as important, or more so, than with the IHS, and (6) proactive planning and service delivery initiatives must begin immediately.

**The 1996 Conference.** For 1996, NlCOA headlines its activities with its biennial conference, "Honoring Indian

# White House Conference on Aging

Indian Country's expectations were high leading into the 1994 White House Conference on Aging, scheduled for May 1995. In 1992, the National Indian Council on Aging had conducted one of the nation's few official pre-event conferences, drawing more than 1,500 registrants to Green Bay, Wisconsin. When the full White House Conference was postponed by Congress, Indian advocates nevertheless felt that their work had been productive, resulting in a comprehensive National Indian Aging Agenda for the Future. In 1994, an even larger pre-event conference was held in Spokane, Washington, attracting 1,600 participants. There, a resolution was passed requesting 64 delegates to the White House conference.

Serious concerns quickly followed. First, it was learned that only 20 Indian Country delegates would be named, including two Native Hawaiians. With some states sending more than a hundred delegates, Indian advocates feared that their voices would be lost in the sheer numbers of delegates at the conference. Only one Alaska Native delegate, for example, was named to represent Native peoples throughout that entire state. Advocates felt that Indian Country delegates would have to be highly organized to compensate for their small delegation size.

Secondly, it became apparent that the democratic nature of the conference Issue Resolution Development Session (IRDS) process would jeopardize Indian initiatives. Would a tiny Indian delegation be able to sway large groups of non-Indians, who would be focused on their own concerns? A two-pronged strategy evolved. Indian delegates would attempt to attach Indian provisions to larger resolutions emerging from the IRDS. Indian delegates would also attempt to secure enough votes for a single floor resolution reaffirming the all-important basis for services to Indian Country, the federal trust responsibility.

A few weeks prior to the conference, Indian and Native Hawaiian delegates arrived in Albuquerque for a two-day strategic planning session. "Deliverable" issues were prioritized, assignments were made, the "IRDS" process was explained, and techniques for effective small-group advocacy were explained. This pre-conference session was to prove invaluable.

Native delegates arrived at the White House conference to find personalized packets awaiting them, a van with a driver available, and nightly caucuses scheduled. Each caucus reviewed that day's progress, resulting in advocates being reassigned to bring additional support to IRDS sessions where opposition was encountered. The technique proved highly effective, as Indian delegates orchestrated provisions in seven of nine targeted sessions. The floor resolution did not obtain the required thousand-vote minimum, although Indian and Hawaiian delegates were able to achieve double the number of signatures required to get it on the floor.

Strategically, the Native American conference effort was a huge success. In actuality, the sheer weight of numbers of voting delegates somewhat nullified the sympathetic response that Indian Country advocates generated. Clearly, Indian-specific issues cannot prevail in democratic referendums that address broad issues (e.g., Medicare, Medicaid) affecting all older Americans.

In retrospect, the dilemma faced by Indian advocates at the White House conference mirrors those faced by Native people in the larger society. Can America be made aware of its federal trust responsibility? Can the fate of the least among us still be advanced legislatively because an honorable country, like an honorable man, always keeps its word? We are watching.

Elders: NICOA's 20th Anniversary." Scheduled for August 29-30 at the Albuquerque Convention Center, the conference is expected to draw up to 2,000 registrants, including more than a thousand elders representing 130 tribes. The 1994 conference featured many sessions relevant to Indian elders, including "Elder Health" presented by Julia Davis, Chair of the National Indian Health Board; "Indian Veterans: A Proud Tradition" by Kathy Jurado, Assistant Secretary, Department of Veterans Affairs; and "AARP and the Older Indian" by Lovolla Burgess, Past President, American Association of Retired Persons. The 1996 conference agenda, featuring evening entertainment by the Ehecatl Aztec Dancers, will be available in June.

**The White House Conference on Aging.** In May 1995, NICOA led a 20-member delegation of Indian advocates to the White House Conference on Aging in Washington, D.C. The conference is mandated by law to be conducted every ten years. For Indian Country, the White House event represented the culmination of several years' efforts: NICOA had conducted pre-conferences in both 1992 and 1994 and had supplied extensive input into the national event. A summary of Indian participation can be found on page 64 (see White House Conference on Aging).

**The Older Americans Act.** America's older Indians depend heavily on Older Americans Act (OAA)* programs. The OAA is usually reauthorized every three years, and is currently pending action on both sides of Congress. As these programs are now universally jeopardized by proposed bills in both the House and Senate, Indian advocates hope that the 1996 reauthorization will be delayed sufficiently (indefinite delays now appear probable) to allow Indian advocates more opportunity to influence their outcome. The potential results of proposed legislation are briefly summarized below.

- *Existing language authorizing Indian Country elder protective activities would be lost.* Title VII of the OAA provides for protective services for the elderly, with Part B specifically addressing Native Americans. Although some "Elder Rights" activities will survive, we will probably lose the current $5 million Part B authorization for tribal elder protective programs. Although Part B has yet to be funded, it offers the sole opportunity for federal elder protection funding. Unlike state units an aging, rural tribes have few opportunities for networking or sharing resources with other state agencies. Without funding for Part B, many reservation and Alaska Native elders will continue to receive no protection whatsoever from abuse.
- *Native American Programs, currently operating at about 60% of adequate levels, would be further reduced by 8%.* Title VI ("Native American Programs") of the OAA provides for nutrition services to Native American elders. The nation's 227 Title VI programs (reservation senior centers) are the cornerstone of OAA services to Indian elders. The Title will now apparently be retained, not merged with state programs as earlier proposed, as will the Native Hawaiian section (Part B). Funding levels would drop by 8%. Authorization levels would reportedly be established at levels slightly higher than appropriations, a decrease of more than $10 million from the Act's current $30 million level.
- *The Senior Community Service Employment Program (SCSEP) might be block granted to tribes and states rather than operated by national sponsors.* The debate over whether to continue the operation of the SCSEP by national sponsors is one of the hottest issues of the reauthorization. Republicans would like to block grant the program to states. Democrats, responding to substantial pressure from the national contractors, are backing the maintenance of the program as is. In either case, the survival of NICOA's SCSEP program is now probable, as both House and Senate have agreed that if SCSEP is block granted to states, it should also be block granted to tribes, and that Indian non-profits (such as NICOA) would be eligible. In either case, the program will be moved from the Department of Labor to the Administration on Aging. NICOA continues to advocate, along with the other national sponsors, for the program to be retained in its current form.

  The proposed $46 million decrease to the SCSEP would further erode what is frequently a sole source of income for Indians, the nation's most impoverished elders. The program provides elders with minimum wages and employment training. It provides valuable services to Title VI and other community programs. NICOA's portion is $5 million, most of which is paid directly to 800 Indian (and other) elders in a dozen states.
- *Research and Demonstration Grants would be virtually eliminated. Indian Country advocates, including NICOA, the National Association of Title Vl Grantees, and the two university-based resource centers on Native American Aging would either be lost or severely crippled.* Title IV (Research and Demonstration Grants), which funds $26 million in annual discretionary grants, will either be eliminated or substantially reduced. Title IV currently provides for demonstration and research grants, university-based resource centers on older Indians, training programs for Title VI directors, and core funding for both NICOA and the National Association of Title VI Grantees. If Title IV is eliminated, most research and key functions of advocacy would cease altogether for Indian elders.
- *Authorization for the Native American Director's position within the Administration on Aging (AoA) would be lost.* The AoA will be allowed to retain an office of Native American programs, but its authority would be unspecified and its function would be reduced from one of official advocacy to one of mere oversight. ®

* The report can be obtained by writing to the National Indian Council on Aging, 6400 Uptown Boulevard, N.E., Suite 510W, Albuquerque, NM 87110 (phone: 505-888-3302; fax: 505-888-3276).

# The Oklahoma Geriatric Education Center

The Oklahoma Geriatric Education Center (OkGEC) is the educational branch of the Oklahoma Center on Aging. It is funded in part by the Geriatric Initiatives Branch of Associated Dental and Public Health Services of the U.S. Department of Health and Human Services. The OkGEC is an educational resource center for the teaching faculty of health and human services' professional programs in higher education institutions as well as for health care professionals working directly with the elderly population in the State of Oklahoma.

The Red Earth Gerontology Scholars (REGS) program, one of the offerings provided by the OkGEC and being piloted in 1996, is designed to assist faculty from rural universities and colleges, as well as tribal health educators, in addressing the needs of the rural and Indian elderly populations in the state. The program includes 100 hours of training with heavy emphasis upon self-paced tutorials, completed at the scholar's convenience.

The Center also conducts an annual Summer Geriatric Institute (SGI). The SGI is designed to afford health and human services providers an opportunity to gain knowledge of interdisciplinary approaches to health care for the elderly. It also provides an opportunity for interdisciplinary and interinstitutional networking. This year's SGI will be held June 12-13, 1996, and its theme is "Towards 2000: Serving the Elderly in an Era of Uncertainty."

The OkGEC has also produced several "trigger" videos and teaching modules dealing with aging issues. The trigger videos are short videotapes designed to present a topic and generate discussion within the group using the tape. In many cases, they are not intended to present solutions, but to engage participants in discussions and encourage them to search for solutions. One tape, *Ethical Issues in Nursing Home Placement*, presents a case, and asks participants how they would decide the issue. Another tape, *Cultural Issues in Native American Health Care: Grandma Goes to Clinic*, examines some of the problems that can be encountered by Indian elders seeking health care.

In addition, the OkGEC has produced a number of geriatric teaching modules (e.g., Polypharmacy in the Elderly, Native American Health Care) and several computer assisted learning programs (e.g., Falls in the Elderly, Urinary Incontinence).

The OkGEC has worked with health trainers of the numerous tribes in Oklahoma to provide educational opportunities for those working directly with the elderly Indian population. Videotapes and teaching modules are for sale through the Center. For a product order form or more information, contact the Oklahoma Geriatric Education Center, P.O. Box 26901, CNB-407, Oklahoma City, OK 73190 (phone: 405-271-8558; fax: 405-271-3887). ®

# The Native Elder Health Care Resource Center

The Native Elder Health Care Resource Center (NEHCRC), located at the University of Colorado Health Sciences Center in Denver and funded by the Administration on Aging under Title IV of the Older Americans Act (OAA), is a national resource center for older American Indians, Alaska Natives, and Native Hawaiians. It has a special emphasis on culturally competent health care. The NEHCRC is one of two such Centers in the country, the purpose of which is to conduct applied research, disseminate information, provide training and technical assistance, and enhance professional education. The NEHCRC's focus is cross-cut by four themes that guide our substantive work: (1) ascertaining health status and condi-

tions, (2) improving practice standards, (3) increasing access to care, and (4) mobilizing community resources.

A major method for dissemination of information by the NEHCRC is a computerized electronic telecommunications system, Denver Free-Net (DFN). DFN provides access to NEHCRC-generated data as well as discussion groups, technical assistance re-sources, and exemplary programs relating to the health care of Native American elders. It is free to the user and can be accessed by modem (dial 303-270-4865) or via internet (telnet freenet@uchsc.edu). NEHCRC can also be found on World Wide Web (WWW). NEHCRC has its own home page and its URL address is http://www.uchsc.edu/sm/nehcrc.

One of the goals of the NEHCRC is to collaborate with the Colorado Geriatric Education Center (also at the University) in the development of four educational modules that may be used for continuing education credit by health professionals and paraprofessionals. The unique feature of these educational modules is that they provide culturally relevant information on disease entities that impact Native American Elders. The topics of the modules are Depression in the Native Elder, Diabetes Type II, Alcohol Abuse, and Cancer. The modules include case-based scenarios that exemplify aspects of these diseases in Native elders. Each module discusses the prevalence of the disease in both the dominant and American Indian and Alaska Native populations, and the diagnosis, treatment, and management of the condition. Emphasis is given to the provision of appropriate and culturally relevant care. Although there has been a lot of information published elsewhere about these disease entities, little of it has included information about cultural variations in health beliefs and practices that may play a significant role in the treatment and management of the underlying process. These continuing education modules are expected to be ready for distribution by July 1996.

A videotape portraying a "culturally-sensitive" interview with an American Indian woman elder with diabetes has also been produced by the Colorado Geriatric Education Center. This one-hour videotape, "How to Conduct a Culturally Relevant Interview," presents methods for integrating the ethnographic/anthropologic interview with the usual medical health assessment. Members of diverse cultural groups have unique ways of identifying and coping with illness that are strongly influenced by their cultural reference group. The demonstration interview is a powerful motivator for clinicians to learn an interviewing process that has the potential for enhancing diagnostic accuracy, improving the likelihood of patient compliance with the treatment regimen, and influencing health promotion and disease prevention behaviors. Implementing these simple methods, the clinician can gain a better understanding of how patients perceive illness and their roles in maintaining wellness. The videotape is available for purchase ($25) by contacting Elaine Robinson, University of Colorado Health Sciences Center, Box A094, 4200 East 9th Avenue, Denver, CO 80262 (phone: 303-270-8974).

For additional information about the educational modules, please contact Ernestine Kotthoff-Burrell, MS, RN-C, ANP, Associate Director for Education, University of Colorado Health Sciences Center, Box A094, 4200 East 9th Avenue, Denver, CO 80262 (phone: 303-270-8974; e-mail: kotthoff-e@prophecy.uchsc.edu).

For more information about the NEHCRC, please call Jeanene Diana, MA, Information Specialist, NEHCRC, University of Colorado, Department of Psychiatry, Campus Box A011-13, 4455 East 12th Avenue, Denver, CO 80220 (phone: 303-372-3250; e-mail: jeanene.diana@uchec.edu). ®

# Sharing Ideas and Information

Two of the goals of the IHS Elders Initiative Committee are to collect information about programs and activities designed to serve the elderly and make it available to others. Frequently, it is difficult to obtain this type of information. To support the Committee's goals and to foster communication (also a goal of *The Provider*), the editors ask that you, our readers, share information and ideas through this publication.

Are you involved with, or do you know someone involved with, an interesting or innovative activity working with the elderly? For example, we have heard that there is a Senior Complex in Kyle, SD and another in Pine Ridge, SD. We also learned that there is a foster grandparent program in Pine Ridge. What's happening at your location? Drop us a line. Send your ideas (and include your name, address, and daytime phone number) to Editor, *The Provider,* IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, AZ 85016 (fax: 602-640-2138; e-mail: provide@ihs.ssw.dhhs.gov).

The editors will summarize the information collected, and forward it to the Committee. In addition, we will prepare a follow-up article describing some of these activities. ®

# The National Resource Center on Native American Aging

The National Resource Center on Native American Aging was established in 1994 at the University of North Dakota (UND) in Grand Forks. The resource center is a collaboration between the UND Office of Native American Programs, the UND Center for Rural Health, and the UND Resource Center on Gerontology.

The National Resource Center on Native American Aging, serving the elderly Native American population of the United States, is committed to increasing awareness of issues affecting American Indian, Alaskan Native, and Native Hawaiian elders and to being a voice and advocate for their concerns.

Through education, training, technical assistance, and research, the center assists in developing community-based solutions to improve the quality of life and delivery of related support services to this aging population.

The center also serves as a focal point for the development and sharing of technical information and expertise to American Indian organizations, Title VI* grantees, Native American communities, educational institutions, and professionals and paraprofessionals in the field.

Completed and ongoing research at the National Resource Center on Native American Aging includes topics of specific concern to elders, including home and community based long term care services in Native American communities, health care utilization among native elders, oral and dental care, and research aimed at preventive care concerning tragedies such as lower extremity (foot) amputations among elder Native American diabetics.

In spring 1995, the UND National Resource Center on Native American Aging held town meetings in reservation and urban American Indian communities across a four state area, gathering information to be forwarded to the White House Conference on Aging. In June 1995, the center hosted a successful Geriatric Leadership Project Seminar for individuals with an interest in Native elder issues, entitled "Service Enhancement: Empowering Lives of Elders." The Center also organized and hosted the First Annual Conference for North American Indians on Aging, Health, and Human Services held November 30 - December 3, 1995 in Mesa, Arizona. The conference, "Honor, Spirit, and Wisdom of Elders: The North American Indian Experience," was widely attended by elders, as well as professionals.

For more information about the Center, or to receive a subscription to Native Aging Visions, contact Alan Allery, Director, National Resource Center on Native American Aging, University of North Dakota, P.O. Box 7090, Grand Forks, ND 58202-7090 (phone:701-777-3766, or 701-777-3293, or 1-800-896-7628; Internet: udrcog@badlands.nodak.edu). ®

* Under Title VI of the Older Americans Act, grants are awarded annually to provide supportive and nutrition services to Native American elders. Persons eligible for services under Title VI are American Indian, Alaska Native, or Native Hawaiian elders living in a Title VI service area.

## *MEETINGS OF INTEREST ®*

**Obstetrical Ultrasound**
**July 17-19, 1996**

This three-day OB/GYN imaging and diagnostic ultrasound course is specifically aimed at physicians in practice, first and second year OB/GYN residents, certified nurse midwives, and nurse practitioners, who wish to learn and improve their "basic" skills of performing and interpreting basic anatomic ultrasound examinations. Anyone who has been performing real-time ultrasound procedures for less than 24 months should benefit from participation.

The course includes three half-days of didactic presentation and discussion sessions and three half-days of supervised, hands-on, practical sessions in small groups. This permits the participants to perfect their skills and put into practice the measurements and calculations discussed in the didactic portion of the course.

This activity is sponsored by the Uniformed Services University of the Health Sciences (USUHS). USUHS designates this activity for 23 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association and for 27.6 contact hours of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.

For more information, contact LT Tim Osbon, Continuing Health Professional Education, USUHS, 4301 Jones Bridge Road, Bethesda, MD 20814-4799 (phone: 301-295-3106).

# Reflections on Health Care for American Indians

*"…our only doctors were the Navajo medicine men."*

In the early days there wasn't any health care of the Indian elderly on the Navajo reservation; our only doctors were the Navajo medicine men. In those days, when the children or the elderly got sick the medicine man usually performed healing ceremonies for the patients or did treatment with Indian medicines.

Today, the most important thing is to educate the young and old to learn and to understand about health care needs. Indian people need to participate in planning and operating health services for their own people. There must be education about care needs of Indian tribes. Much needs to be done for disease prevention and long-term care needs for the elderly in the nursing homes with medical problems.

We come upon the brink of time, the close of a century; we've just begun to realize our responsibilities. It will reflect the plans we make, the visions we now see. We have to work together to be all we can be.

Riley Freeland (Navajo)
Highland Manor Nursing Home
Phoenix, Arizona

# Identifying Elders' Health Care Concerns

*John Saari, MD, Medical Educator, IHS Clinical Support Center, and Staff Physician Family Practice and Geriatrics, Phoenix Indian Medical Center, Phoenix, Arizona.*

*The old man had no ride to clinic, so he walked into town to get to the hospital. He shouldn't have been walking that far. He waited for a long time, but they told him that he couldn't be seen that day, so he walked home.*

Sometimes we may assume that if we don't hear any complaints, then everything must be OK. My work in geriatrics has shown me that many of my older patients aren't inclined to voice their complaints. However, if they are asked, they do have some constructive criticism about how the services they receive may be improved.

You might want to ask some of your older patients what they think of the care they receive and how it could be better. Another way to identify unmet needs of elders is to see if the tribe you work with has an "elders concerns group" (or something like it), a meeting where the elders speak their mind about health care and many other matters. A member of that group will probably be willing to share the problems they have discussed. You might also establish an elders advocacy group at your facility, a forum where health care providers from many disciplines and representatives of the elders meet to find out how to work together to improve care.

Here are some common concerns I've heard from these and other sources:

- "The waiting time is too long and I can't sit that long."
- "I want to see the same doctor each time so that I don't have to go over my story again and again."
- "I see one doctor one time and another the next — they tell me a different diagnosis each time, and give me a different medicine. I worry that the medicines don't go together."
- "I don't speak English and sometimes there is no one to translate."
- "We don't assert ourselves and ask for what we want or need."
- "The doctor I see doesn't specialize in the care of older people."
- "It's too hard to get to clinic and there is no transportation available."
- "There should be a special day or a special clinic for older people with shorter waits and everything set up right there to care for older people."

You may want to take some steps to find out what your older patients are saying and feeling about the care they get. There may be some simple things you can do to improve their satisfaction. The harder things you can tackle in due time. ®

## NATIVE AMERICAN MEDICAL LITERATURE ®

*The following is an updated MEDLINE search on Native American medical literature. At the end of each cited article, you will find a unique identifying (UI) number. For those of you who may wish to obtain a copy of a specific article, this can be facilitated by giving the librarian nearest you the UI number as well as the complete citation.*

*If your facility lacks a library or librarian try calling your nearest university library, the nearest state medical association, or the National Library of Medicine (1-800-272-4787) to obtain information on how to access journal literature within your region. Bear in mind that most local library networks function on the basis of reciprocity and, if you do not have a library at your facility, you may be charged for services provided.*

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Authors should submit at least one hard copy with each electronic copy. Manuscripts may be received via the IHS Banyan electronic mail system. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities/Area Publications Committees to publish manuscripts rests with the author. For those who would like some guidance with manuscripts, a packet entitled "Information for Authors" is available by contacting the CSC at the address below.


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